BURNS - PEDIATRIC
(Less Than 15 Years of Age)

Any burn patient requires effective, communication and rapid transportation to the closest receiving hospital.

In Inyo and Mono Counties, the assigned base station should be contacted for determination of appropriate destination.

FIELD ASSESSMENT/TREATMENT INDICATORS

Burn Criteria and Destination Policy # 8030

PEDIATRIC TREATMENT PROTOCOL: BURNS

Base Station Contact Shaded in Gray

BLS INTERVENTIONS	ALS INTERVENTIONS
• Break contact with causative agent (stop the burning process) • Remove clothing and jewelry quickly, if indicated • Keep patient warm • Estimate % TBSA burned and depth using the "Rule of Nines" o An individual's palm represents 1% of TBSA and can be used to estimate scattered, irregular burns • Transport to ALS intercept or to the closest receiving hospital	• Advanced airway as indicated **Airway Stabilization:** Burn patients with respiratory compromise or potential for such, will be transported to the closest receiving hospital for airway stabilization. • Monitor ECG • IV/IO Access: Warm IV fluids when avail *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion, start 2nd IV access. o *Administer* 20ml/kg NS bolus IV/IO, may repeat once. *Stable*: Vital signs (age appropriate) and/or signs of adequate tissue perfusion. **≤ 5 years of age** o *IV NS* 150ml/hour **> 5 years of age - < 15 years of age** o *IV NS* 250ml/hour • Treat pain as indicated

BLS Continued	***ALS Continued***
	IV Pain Relief: Morphine Sulfate 0.1mg/kg IV/IO slowly, do not exceed 5mg increments, may repeat every 5 minutes to a maximum of 20mg IV/IO when the patient maintains age appropriate vital signs and adequate tissue perfusion. Document vital signs every 5 minutes while medicating for pain, and reassess the patient. **IM Pain Relief:** Morphine Sulfate 0.2mg/kg IM, 10mg IM maximum. Document vital signs and reassess the patient. • Transport to appropriate facility: *CTP with associated burns:* transport to the closest trauma hospital. • Burn patients with associated trauma, should be transported to the closest Trauma Center. Trauma base station contacted shall be made. • Insert nasogastric/orogastric tube as indicated Refer to Burn Classification Table.
MANAGE SPECIAL CONSIDERATIONS:	**MANAGE SPECIAL CONSIDERATIONS:**
Thermal Burns: Stop the burning process. Do not break blisters. Cover the affected body surface with dry, sterile dressing or sheet. **Chemical Burns:** Brush off dry powder, if present. Remove any contaminated or wet clothing. Irrigate with copious amounts of saline or water. **Tar Burns**: Cool with water, do not remove tar. **Electrical Burns:** Remove from electrical source (without endangering self) with a nonconductive material. Cover the affected body surface with dry, sterile dressing or sheet.	**Electrical Burns:** Monitor for dysrhythmias, treat according to PALS guidelines and ICEMA policies. • Electrical injuries that result in cardiac arrest shall be treated as medical arrests.

BLS Continued	***ALS Continued***
Eye Involvement: Continuous flushing with NS during transport. Allow patient to remove contact lenses if possible.	**Respiratory Distress:** Intubate patient if facial/oral swelling are present or if respiratory depression or distress develops due to inhalation injury. • 1 day to 12 months old – Nebulized Albuterol 2.5mg with Atrovent 0.25mg, may repeat two (2) times. • 1 year to < 15 years old – Albuterol 2.5mg with Atrovent 0.5mg, may repeat two (2) times. • Administer humidified O2, if available. • Consider capnography, if available. **Deteriorating Vital Signs:** Transport to the closest receiving hospital. Contact base station. **Pulseness and Apneic:** Transport to the closest receiving hospital and treat according to ICEMA protocols. Contact base station.
Determination of Death on Scene: Refer to Protocol # 12010 Determination of Death on Scene.	**Determination of Death on Scene:** Refer to Reference Protocol # 12010 Determination of Death on Scene. **Precautions and Comments:** . • Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact. • Do not apply ice or ice water directly to skin surfaces as additional injury will result. • Do not apply cool dressings or allow environmental exposure, since hypothermia will result in a young child. **Base Station Orders**: May order additional: • medications; • fluid boluses.

REFERENCE PROTOCOLS

Protocol Number	**Protocol Name**
9010	General Patient Care Guidelines
10150	External Jugular Vein Access
10030/10040	Oral Endotracheal Intubation
10080	Insertion of Nasogastric/Orogastric Tube
10060	Needle Thoracostomy
10140	Intraosseous Infusion IO
10050	Nasotracheal Intubation
10070	Needle Cricothyrotomy
10160	Axial Spinal Stabilization
10010/10020	King Airway Device
11070	Adult Cardiac Arrest
15030	Trauma Triage Criteria and Destination Policy
12010	Determination of Death on Scene

BURN CLASSIFICATIONS

PEDIATRIC BURN CLASSIFICATION CHART	DESTINATION	
<u>MINOR</u> - PEDIATRIC • < 5% TBSA • < 2% Full Thickness	**CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL**	
<u>MODERATE</u> - PEDIATRIC • 5 – 10% TBSA • 2 – 5% Full Thickness • High Voltage Injury • Suspected Inhalation Injury • Circumferential Burn • Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease)	**CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL**	
<u>MAJOR</u> - PEDIATRIC • > 10% TBSA • > 5% Full Thickness • High Voltage Burn • Known Inhalation Injury • Any significant burn to face, eyes, ears, genitalia, or joints	**CLOSEST MOST APPROPRIATE BURN CENTER** In San Bernardino County, contact: Arrowhead Regional Medical Center (ARMC)	

"Rule of Nines"